Damian McCleod **Acupuncture** | 917-806-8505 | dmacupuncture.com

Patient Information

Date:___/____/_____

First Name: _____ Last Name:_____

Address:_____

City_____ State_____ Zip_____

Date of Birth:_____/_____/_____ Age:_____ Height:_____ Weight:_____ Gender:_____

Phone:_____-_____-_____ Email:_____

Emergency Conact: __(name)_____(phone)_____-_____-_____

Primary Care Physician: _____

Have you previously been treated with Acupuncture? Yes ☐ No ☐ If yes, when_____

How did you hear about us? _____

Main issues you are seeking treatment for:

#1 _____ Severe ___ Moderate ____ Slight____

Describe your symptoms: _____

When/how did this condition occur? _____

How does this condition impair your daily activities? _____

_____

Treatments have you received for this condition? _____

_____

Medical History:

Illnesses	
Surgeries	
Trauma (accidents, fractures, etc.)	
Infectious diseases	
Allergies / sensitivities	

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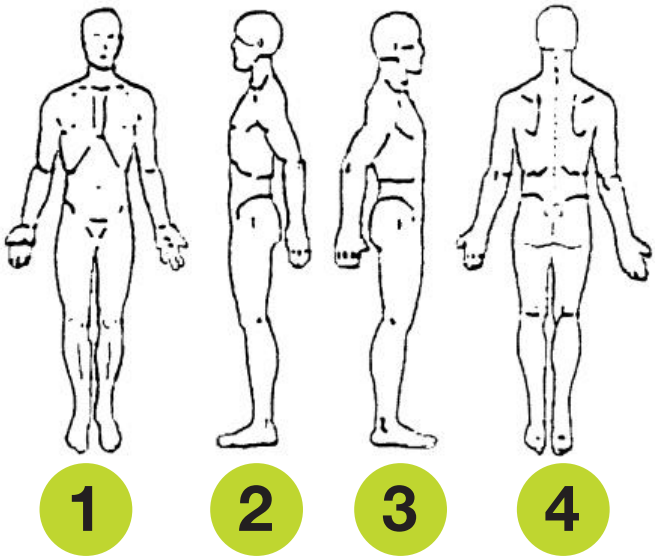
Date:___/____/_____

List all prescription medications and suppliments you currently take:

Medication/Dose	Purpose	Length of Time	Last Dose

Musculoskeletal pain:



Draw a circle around the area of pain, and place an "**X**" next to the nature of the pain for that area.

Area 1: Sharp ☐ Burning ☐ Achey ☐

Area 2: Sharp ☐ Burning ☐ Achey ☐

Area 3: Sharp ☐ Burning ☐ Achey ☐

Area 4: Sharp ☐ Burning ☐ Achey ☐

Symptoms

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows: No mark = never experience, **1** = sometimes experience, **X** = frequently experience

__ Lack of Appetite
__ Excessive appetite
__ Loose stool or diarrhea
__ Digestive problems
__ Vomiting
__ Belching, burping
__ Colitis or diverticulitis
__ Constipation
__ Hemorrhoids
__ Blood in stool
__ Heartburn/reflux
__ Retention of food in the stomach
__ Obsessive in work, relationships...
__ Insomnia
__ Heart palpitations
__ Cold hands and feet
__ Nightmares
__ Mentally restless
__ Laughing for no reason
__ Abdominal pain
__ Chest pain
__ Sciatic pain
__ Headaches
__ Pain or coldness in the genital area
__ Cough
__ Shortness of breath
__ Decreased sense of smell
__ Nasal problems
__ Skin problems
__ Claustrophobia
__ Bronchitis
__ Recent use of antibiotics
__ Eye problems
__ Jaundice (yellowish eyes or skin
__ Gall stones
__ Light colored stool
__ Soft or brittle nails
__ Easily angered
__ Difficulty making decisions
__ Muscle spasms
__ Low back pain
__ Knee problems
__ Hearing impairment
__ Ear ringing
__ Kidney stones
__ Decreased sex drive
__ Hair loss
__ Fatigue
__ Edema
__ Black tarry stool
__ Easily bruised
__ Difficult to stop bleeding
__ Asthma
__ Tendency to catch colds
__ Intolerance to weather changes
__ Allergies
__ Hay fever
__ Dizziness
__ Tendency to faint easily
__ High cholesterol levels
__ Sudden weight loss

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Date:___/____/_____

*Please answer the following questions or circle anything that may apply.

Sleep: Hours per night_____ Time to bed_____ Time to rise_____

Feel rested in the AM? Yes ☐ No ☐ Trouble falling Asleep? Yes ☐ No ☐

Wake during the night? Yes ☐ No ☐ Vivid dreaming? Yes ☐ No ☐

Digestion: Good appetite? Yes No Cravings for certain foods? _____

What did you eat and drink yesterday?

_____

_____

Bowel movements: Frequency _____Feels complete? Yes ☐ No ☐ Sometimes ☐

Consistency: ☐ Well-formed ☐ Hard Loose ☐ Alternates day to day

Pain ☐ Blood ☐ Undigested ☐ food ☐ Mucus ☐ Gas/Bloating ☐ Acid Reflux ☐ Other ☐

Urination: Difficulty ☐ Burning ☐ Urgent ☐ Frequent ☐ Scanty ☐ Dribbling ☐

Cloudy ☐ Dark ☐ Pale ☐ Edema (swelling of limbs) ☐

Libido: Low ☐ High ☐ Any complications with sexual function? Yes ☐ No ☐

Immunity: Frequent colds ☐ Allergies ☐ History of respiratory infection?

Frequent Antibiotic Use (current or past)?_____

How is your Energy Level? _____

Stress Level?_____

For Women

Menstruation: Long ☐ Short ☐ Irregular Menstrual Cycles ☐ Painful Menses ☐ Clots/Heavy Bleeding ☐

Breast Tenderness ☐ Scanty Bleeding ☐ Bleeding Between Cycles ☐ Profuse Discharge ☐

Birth Control Pills? ☐ (now/past)

Number of Pregnancies?___ Number of Children?___

If you have children; how is their health?_____

Work: What do you do for work? _____ Enjoy work?_____

Hours per week working _____

Are you thirsty often? Yes No If so do you crave warm or cold drinks? _____

Do you find that you “run” particularly hot or cold?_____

Do you often get headaches or migraines? Yes/No Where?_____ Dull or Stabbing?

Anything else with ears/eyes/nose/throat? Frequent feeling of your heart beating?

Body Pain? Where and How Long?_____

Anything else you would like us to know?_____

_____

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Date:___/____/_____

PATIENT ADVISORY TO CONSULT A PHYSICIAN

Damian McCLeod Acupuncture is committed to your health and well-being. While Oriental medicine has a great deal to offer as health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education law, it is requested that you read and sign the following statement:

I undersigned, do affirm that _____ has been advised by Damian McCLeod Acupuncture to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature _____ Date ____/____/_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: _____

PATIENT SIGNATURE **X** _____ Date _____/_____/_____

(Or Patient Representative) (Indicate relationship if signing for patient)

Date:___/____/_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE X_____ Date _____/_____/_____